

HOSPITAL BEDS STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Wednesday, October 27, 2004

Michigan Manufacturer's Association (MMA)
620 South Capital Avenue
1st Floor Conference Room
Lansing, MI 48933

APPROVED MINUTES

I. Call to Order.

Chairperson Dale Steiger called the meeting to order at 10:09 a.m.

a. Members Present and Organizations Represented:

Dale L. Steiger, Blue Cross Blue Shield of Michigan, Chairperson
Robert Asmussen, Ascension Health/St. John Health System
James F. Ball, Michigan Manufacturers Association
Brooks F. Bock, MD, Wayne State University (Alternate)
(arrived at 10:30 a.m. and left at 12:00 noon)
Greg S. Dobis, McLaren Health Care (arrived at 10:25 a.m.)
James B. Falahee, Jr., Bronson Healthcare Group
Stephen Fitton, Michigan Department of Community Health (arrived at 11:40 a.m.)
John Graham, Beaumont Hospitals (Alternate)
Maureen A. Halligan, Genesys Health System
Denise Holmes, Michigan State University, College of Human Medicine
Carol Parker Lee, Michigan Primary Care Association
Robert Meeker, Alliance for Health
Elizabeth Palazzolo, Henry Ford Health System (Alternate)
Anne Rosewarne, Michigan Health Council
Thomas Smith, Economic Alliance for Michigan
Kenneth G. Trester, Oakwood Healthcare, Inc. (arrived at 10:15 a.m.)
Robert Yellan, The Detroit Medical Center (Alternate)

b. Members Absent and Organizations Represented:

John D. Crissman, MD, Wayne State University, School of Medicine
Eric Fischer, The Detroit Medical Center
Sande MacLeod, UFCW 951
Patrick G. O'Donovan, Beaumont Hospitals
Vinod K. Sahney, Henry Ford Health System

c. Staff Present:

Lakshmi Amarnath
Jan Christensen
Tom Freebury (arrived at 1:00 p.m.)
William Hart
Larry Horvath (arrived at 10:20 a.m.)
John Hubinger
Joette Laseur
Andrea Moore
Stan Nash
Brenda Rogers
Gaye Tuttle

d. General Public in Attendance:

There were approximately 25 people in attendance.

II. Declarations of Conflicts of Interest.

None were noted.

III. Review of Agenda.

Chairperson Steiger added under Other Business an item B. Discussion of Replacement Zone. Motion by Mr. Falahee, seconded by Mr. Meeker, to accept the agenda as adjusted. Motion Carried.

IV. Review of Draft Minutes of October 12, 2004.

Section VI (a) add 'not' after population of and add 'utilizing slowest route according to MDOT' after travel time methodology. Motion by Dr. Ball, seconded by Mr. Graham, to accept the minutes as adjusted. Motion Carried.

V. Access Work Groups - Update.

Mr. Meeker reviewed a written report (Attachment A) and provided an overview of the workgroup's progress. Discussion Followed.

Larry Horwitz, Economic Alliance, addressed the Committee.

Discussion followed.

Motion by Mr. Graham, seconded by Mr. Asmussen that the Committee accepts the report of the Hospital Access Workgroup from October 27, 2004. The Committee also recommends that further refinements of the travel time approach should be undertaken for consideration as soon as technically possible in 2005. The further potential refinements should focus on population based alternatives related to access to sufficient hospital capacity.

Discussion followed. Mr. Christensen provided the Committee with information on hospital size (Attachment B).

Motion Carried.

Lunch Break from 11:45 – 1:07 p.m.

VI. Review of Proposed Language – Travel Time.

Ms. Rogers reviewed the proposed language (Attachment C). Discussion followed. Ms. Rogers will continue to work with the Work Group to modify the proposed language and add the additional information from Michigan State University's final report.

Amy Barhotz, MHA, addressed the Committee.

VII. Review of Proposed Language – High Occupancy.

Ms. Rogers reviewed the proposed language (Attachment C).

Motion by Mr. Graham, seconded by Mr. Ball, to accept the language as proposed.

Discussion followed.

Mark Mailloux, University of Michigan, addressed the Committee and provided a written overview (Attachment D).

Larry Horwitz, Economic Alliance, addressed the Committee.

Motion by Mr. Graham, seconded by Ms. Halligan, to add that a hospital, which has transferred beds within its system, is ineligible to apply for high occupancy for 5 years.

Peg Reihmer, Botsford General Hospital, addressed the Committee.

Penny Crissman, Crittenton Hospital, addressed the Committee.

Motion by Mr. Ball, seconded by Mr. Asmussen, to table both current motions and submit the issue to the work group. Motion Carried.

The work group asked that written proposals on this issue be sent to the Committee and the work group by Friday at 12:00 noon.

VIII. Comparative Review Work Group - Update.

Ms. Reihmer gave an overview of the work group's progress. The work group will be meeting on Friday, October 29, 2004, at the Lewis Cass Building, to finalize their recommendations to the Committee.

IX. Other Business.

A. Replacement Zone.

Mr. Asmussen gave the overview of the replacement zone. Discussion followed.

Peg Reihmer, Botsford General Hospital, addressed the Committee.

Larry Horwitz, Economic Alliance, addressed the Committee.

Motion by Mr. Falahee, seconded by Mr. Asmussen, the Committee has looked at the issue and decided to not revise the 2-mile replacement zone, as a component of the travel time analysis, population based analysis, and comparative review analysis.

Discussion followed.

Motion Carried.

X. Future Meetings and Agendas - November 10, 2004.

No changes made.

XI. Public Comment.

None received.

XII. Adjournment.

Motion by Mr. Ball, seconded by Mr. Falahee, to adjourn the meeting at 3:00 p.m. Motion Carried.

Hospital Access Work Group

Report to the Hospital Bed SAC

October 27, 2004

In response to the report presented to the SAC on October 12, 2004, the Hospital Access Work Group was asked to investigate several issues further related to access to hospitals beds. They are as follows:

- 1) Hospital bed size recommendations
- 2) Identification of "limited access areas"
- 3) Minimum population size of "limited access areas"
- 4) Needed urban – rural differences in the travel time approach
- 5) Reconsideration of the population-based proposal
- 6) Development of draft language for the Hospital Bed Review Standards
- 7) Should there be preference for new or transferred beds

Recommendations of the Work Group related to these issues are as follows:

Hospital bed size recommendations

The Work Group reiterates its recommendation that no additional restriction on the number of beds be placed on applicants seeking to take advantage of the travel time exception, other than the guidelines contained in the existing CON Review Standards. Rather the Work Group recommends that the acute care bed need methodology (ACBNM) be applied to the population of each limited access area to determine the maximum number of beds needed for that area. The bed size of any new hospital authorized on the basis of the travel time exception could not exceed the number of beds needed in the limited access area, as calculated by the ACBNM.

Identification of "limited access areas"

Several discrete "limited access areas" are identified on the maps provided by the MSU geography department, including the following prominent areas:

1. Western St. Clair County and part of northern Macomb Co.
2. An area west and south of Alpena
3. A crescent-shaped area east of Traverse City
4. Much of the Upper Peninsula

Stan Nash is working with representatives of the MSU Geography Department to convert these mapped areas into zip-code-based populations, in order to determine which of them qualify as “limited access areas.”

Minimum population size of “limited access areas”

The Work Group reiterates its recommendation that the minimum population size of 50,000 residents be applied to contiguous areas outside of 30 minutes from existing hospitals to determine if they qualify to be designated as limited access areas. The Work Group further recommend that the population estimates for the planning year, as defined in the Standards, be employed in making this determination.

Needed urban – rural differences

The Work Group preliminarily recommends that there be no differences between metropolitan and non-metropolitan areas in applying the travel time approach. In the absence of any representatives from rural areas, the Group agreed to consult with rural representatives before making final recommendations on this issue.

Reconsideration of the population-based proposal

The Work Group approved the following recommendation:

The SAC should reiterate its approval of the travel time proposal, with the understanding that further refinements should be undertaken for consideration by another SAC next year. The further potential refinements focus on population-based alternatives related to access to sufficient hospital capacity.

Development of draft language for the Hospital Bed Review Standards

A small working group volunteered to assist Brenda Rogers in developing draft language for the Standards, as presented in a separate document.

Comparative Review Criteria

The Work Group recommends the following comparative review criteria to be used for CON applications seeking approval under the travel time exception:

- 1) Underserved population targeted by proposed new hospital:

Higher comparative review “points” should be awarded to applicants with larger numbers of people in the identified limited access area who are within 30-minute travel time from the proposed location of the new hospital.

2) Closure of existing hospitals/beds

- a. Maximum points should be given to an application which includes the closure of an existing hospital in an overbedded area within the same HSA as the proposed project.
- b. Some points should be awarded to an application which includes the closure of an equal number of hospital beds in an overbedded area within the same HSA as the proposed project.
- c. No points should be awarded if there is no corresponding closure of hospital beds included in the proposed project.

These comparative review criteria suggestions have been communicated to the separate work group on that subject, prior to its first meeting on October 25.



The IHSP Hospital 200: The Nation's Most -and Least – Expensive Hospitals

Revision 2.01: Embargoed Until June 24, 2003

Includes Hospital Total Charge to Cost Ratios by State, the Top Hospitals for Each, & an Expanded Discussion of Hospital Gross Charges and Medicare Reimbursement Rates

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Bed Deciles	Hospitals	Average Total Charge to Cost Ratio by Bed Deciles	Average Profits	Average Number of Beds
4.	Average Profits/Beds	183.85%	\$883,946.94	55.29
5.	Average Profits/Beds	203.15%	\$1,889,694.65	82.56
6.	Average Profits/Beds	238.01%	\$1,241,918.12	110.29
7.	Average Profits/Beds	234.85%	\$3,139,491.22	143.66
8.	Average Profits/Beds	240.56%	\$1,539,161.39	194.81
9.	Average Profits/Beds	245.30%	\$6,291,230.01	272.34
10.	Average Profits/Beds	243.57%	\$14,108,528.63	491.69

Table 15 Average Total Charge to Cost Ratios by Hospital Bed Deciles

Bed Deciles	Average Total Charge to Cost Ratio by Bed Deciles	Average Number of Beds by Bed Deciles
1	143.87%	19.21
2	156.74%	32.12
3	166.73%	43.51
4	183.85%	55.29
5	203.15%	82.56
6	238.01%	110.29
7	234.85%	143.66
8	240.56%	194.81
9	245.30%	272.34
10	243.57%	491.69



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This year's *100 Top Hospitals* study reveals noteworthy insights based on region and facility size:

- Managed care cutting into regional outpatient revenue.**
 Contrary to general expectations, in the West, 1997 median lengths of stay actually rose with the level of managed care penetration. Furthermore, the study shows that hospitals in the South and West with the highest levels of managed care penetration had the lowest median percentages of outpatient revenue. This could be caused by more patients receiving care in freestanding outpatient clinics rather than in large settings.

 What's more, in markets where managed care penetration has been strong, hospitals with lower levels of managed care have raised their performance standards to match standards at hospitals with higher levels of managed care. Because some of the savings that managed care brought to the industry now appear to have been a one-time benefit, in the future we may see more uniform performance among hospitals with different levels of managed care penetration.
- Small outperforms large.** Smaller hospitals performed better than large hospitals in most criteria — both clinical and financial. In fact, hospitals with 25-99 beds ranked first in all three *100 Top* clinical indicators — mortality index, complication index, and lengths of stay. Although historically we do not expect small hospitals to perform as well as larger hospitals in financial measures, the small benchmark hospitals had the highest outpatient revenue and total asset turnover ratio of any group, and lower expenses than all but the medium-sized benchmark hospitals.

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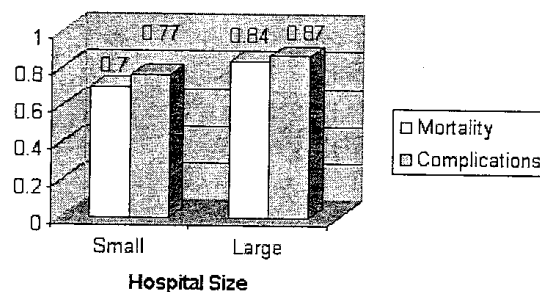
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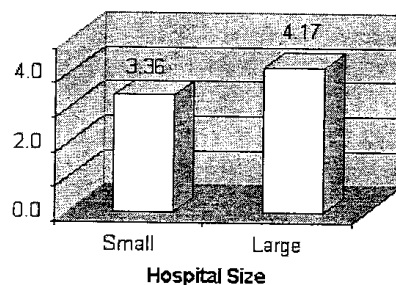
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CERTIFICATE OF NEED (CON) REVIEW STANDARDS FOR HOSPITAL BEDS

(By authority conferred on the CON Commission by sections 22215 and 22217 of Act No. 368 of the Public Acts of 1978, as amended, and sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being sections 333.22215, 333.22217, 24.207, and 24.208 of the Michigan Compiled Laws.)

Section 1. Applicability

Sec. 1. (1) These standards are requirements for approval and delivery of services for all projects approved and certificates of need issued under Part 222 of the Code that involve (a) increasing licensed beds in a hospital licensed under Part 215 or (b) physically relocating hospital beds from one licensed site to another geographic location or (c) replacing beds in a hospital or (d) acquiring a hospital or (e) beginning operation of a new hospital.

(2) A hospital licensed under Part 215 is a covered health facility for purposes of Part 222 of the Code.

(3) An increase in licensed hospital beds is a change in bed capacity for purposes of Part 222 of the Code.

(4) The physical relocation of hospital beds from a licensed site to another geographic location is a change in bed capacity for purposes of Part 222 of the Code.

(5) An increase in hospital beds certified for long-term care is a change in bed capacity for purposes of Part 222 of the Code and shall be subject to and reviewed under the CON Review Standards for Long-Term-Care Services.

(6) The Department shall use sections 3, 4, 5, 6, 7, 8, 10, 15, AND 16 of these standards and Section 2 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(1) of the Code, being Section 333.22225(1) of the Michigan Compiled Laws.

(7) The Department shall use Section 9 of these standards and Section 3 of the Addendum for Projects for HIV Infected Individuals, as applicable, in applying Section 22225(2)(c) of the Code, being Section 333.22225(2)(c) of the Michigan Compiled Laws.

Section 2. Definitions

Sec. 2. (1) As used in these standards:

(a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a hospital with a valid license and which does not involve a change in bed capacity.

(b) "Alcohol and substance abuse hospital," for purposes of these standards, means a licensed hospital within a long-term (acute) care hospital that exclusively provides inpatient medical detoxification and medical stabilization and related outpatient services for persons who have a primary diagnosis of substance dependence covered by DRGs 433 - 437.

(c) "Base year" means the most recent year that final MIDB data is available to the Department unless a different year is determined to be more appropriate by the Commission.

(d) "Certificate of Need Commission" or "Commission" means the Commission created pursuant to Section 22211 of the code, being Section 333.22211 of the Michigan Compiled Laws.

(e) "Code" means Act No. 368 of the Public Acts of 1978, as amended, being Section 333.1101 et seq. of the Michigan Compiled Laws.

(f) "Department" means the Michigan Department of Community Health (MDCH).

(g) "Department inventory of beds" means the current list maintained for each hospital subarea on a continuing basis by the Department of (i) licensed hospital beds and (ii) hospital beds approved by a valid CON issued under either Part 221 or Part 222 of the Code that are not yet licensed. The term does not include hospital beds certified for long-term-care in hospital long-term care units.

(h) "Discharge relevance factor" (%R) means a mathematical computation where the numerator is the inpatient hospital discharges from a specific zip code for a specified hospital subarea and the denominator is the inpatient hospital discharges for any hospital from that same specific zip code.

(i) "Existing hospital beds" means, for a specific hospital subarea, the total of all of the following: (i) hospital beds licensed by the Department; (ii) hospital beds with valid CON approval but not yet licensed; (iii) proposed hospital beds under appeal from a final decision of the Department; and (iv) proposed hospital beds that are part of a completed application under Part 222 (other than the application under review) for which a proposed decision has been issued and which is pending final Department decision.

(j) "Health service area" OR "HSA" means the groups of counties listed in Section 17.

(k) "Hospital bed" means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code and (ii) unlicensed newborn bassinets.

(l) "Hospital" means a hospital as defined in Section 20106(5) of the Code being Section 333.20106(5) of the Michigan Compiled Laws and licensed under Part 215 of the Code. The term does not include a hospital or hospital unit licensed or operated by the Department of Mental Health.

(m) "Hospital long-term-care unit" or "HLTCU" means a nursing care unit, owned or operated by and as part of a hospital, licensed by the Department, and providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

(n) "Hospital subarea" or "subarea" means a cluster or grouping of hospitals and the relevant portion of the state's population served by that cluster or grouping of hospitals. For purposes of these standards, hospital subareas and the hospitals assigned to each subarea are set forth in Appendix A.

(o) "Host hospital," for purposes of these standards, means an existing licensed hospital, which delicenss hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow a long-term (acute) care hospital, or alcohol and substance abuse hospital, to begin operation.

(p) "Licensed site" means either (i) in the case of a single site hospital, the location of the facility authorized by license and listed on that licensee's certificate of licensure or (ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure.

(Q) "LIMITED ACCESS AREA" MEANS THOSE GEOGRAPHIC AREAS OF NOT LESS THAN 50,000 POPULATION BASED ON THE PLANNING YEAR AND AS IDENTIFIED IN APPENDIX E.

(R) "Long-term (acute) care hospital," for purposes of these standards, means a hospital has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt hospital in accordance with 42 CFR Part 412.

(S) "Market forecast factors" (%N) means a mathematical computation where the numerator is the number of total inpatient discharges indicated by the market survey forecasts and the denominator is the base year MIDB discharges.

(T) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and 1396r-8 to 1396v.

(U) "Metropolitan statistical area county" means a county located in a metropolitan statistical area as that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(V) "Michigan Inpatient Data Base" or "MIDB" means the data base compiled by the Michigan Health and Hospital Association or successor organization. The data base consists of inpatient discharge records from all Michigan hospitals and Michigan residents discharged from hospitals in border states for a specific calendar year.

(W) "Micropolitan statistical area county" means a county located in a micropolitan statistical area as that term is defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(X) "New beds in a hospital" means hospital beds that meet at least one of the following: (i) are not currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation in a different subarea as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea as determined by the Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards.

(Y) "New hospital" means one of the following: (i) the establishment of a new facility that shall be issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site that is not in the same hospital subarea as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea as determined by the Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards.

(Z) "Overbedded subarea" means a hospital subarea in which the total number of existing hospital beds in that subarea exceeds the subarea needed hospital bed supply as set forth in Appendix C.

(AA) "Planning year" means five years beyond the base year, established by the CON Commission, for which hospital bed need is developed, unless a different year is determined to be more appropriate by the Commission.

(BB) "Relevance index" or "market share factor" (%Z) means a mathematical computation where the numerator is the number of inpatient hospital patient days provided by a specified hospital subarea from a specific zip code and the denominator is the total number of inpatient hospital patient days provided by all hospitals to that specific zip code using MIDB data.

(CC) "Relocate existing licensed hospital beds" for purposes of Section 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital subarea. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards.

(DD) "Replacement beds in a hospital" means hospital beds that meet all of the following conditions; (i) an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the replacement zone.

(EE) "Replacement zone" means a proposed licensed site that is (i) in the same subarea as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000.

(FF) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical areas as those terms are defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000) and as shown in Appendix B.

(GG) "Utilization rate" or "use rate" means the number of days of inpatient care per 1,000 population during a one-year period.

(HH) "Zip code population" means the latest population estimates for the base year and projections for the planning year, by zip code.

(2) The definitions in Part 222 shall apply to these standards.

Section 3. Hospital subareas

Sec. 3. (1)(a) Each existing hospital is assigned to a hospital subarea as set forth in Appendix A which is incorporated as part of these standards, until Appendix A is revised pursuant to this subsection.

(i) These hospital subareas, and the assignments of hospitals to subareas, shall be updated, at the direction of the Commission, starting in May 2003, to be completed no later than November 2003.

Thereafter, at the direction of the Commission, the updates shall occur no later than two years after the official date of the federal decennial census, provided that:

(A) Population data at the federal zip code level, derived from the federal decennial census, are available; and final MIDB data are available to the Department for that same census year.

(b) For an application involving a proposed new licensed site for a hospital (whether new or replacement), the proposed new licensed site shall be assigned to an existing hospital subarea utilizing a market survey conducted by the applicant and submitted with the application. The market survey shall provide, at a minimum, forecasts of the number of inpatient discharges for each zip code that the proposed new licensed site shall provide service. The forecasted numbers must be for the same year as the base year MIDB data. The market survey shall be completed by the applicant using accepted standard statistical methods. The market survey must be submitted on a computer media and in a format specified by the Department. The market survey, if determined by the Department to be reasonable pursuant to Section 14, shall be used by the Department to assign the proposed new site to an existing subarea based on the methodology described by "The Specification of Hospital Service Communities in a Large Metropolitan Area" by J. William Thomas, Ph.D., John R. Griffith, and Paul Durance, April 1979 as follows:

(i) For the proposed new site, a discharge relevance factor for each of the zip codes identified in the application will be computed. Zip codes with a market forecast factor of less than .05 will be deleted from consideration.

(ii) The base year MIDB data will be used to compute discharge relevance factors (%Rs) for each hospital subarea for each of the zip codes identified in step (i) above. Hospital subareas with a %R of less than .10 for all zip codes identified in step (i) will be deleted from the computation.

(iii) The third step in the methodology is to calculate a population-weighted average discharge relevance factor \bar{R}_j for the proposed hospital and existing subareas. Letting:

P_i = Population of zip code i.

d_{ij} = Number of patients from zip code i treated at hospital j.

$D_i = \sum_j d_{ij}$ = Total patients from zip code i.

$I_j = \{i \mid (d_{ij}/D_i) \geq \alpha\}$, set of zip codes for which the individual relevance factor [%R from (i) and (ii) above] values (d_{ij}/D_i) of hospital j exceeds or equals α , where α is specified $0 \leq \alpha \leq 1$.

$$\text{then } \bar{R}_j = \frac{\sum_{i \in I_j} P_i (d_{ij}/D_i)}{\sum_{i \in I_j} P_i}$$

(iv) After \bar{R}_j is calculated for the applicant(s) and the included existing subareas, the hospital/subarea with the smallest \bar{R}_j ($S \bar{R}_j$) is grouped with the hospital/subarea having the greatest individual discharge relevance factor in the $S \bar{R}_j$'s home zip code. $S \bar{R}_j$'s home zip code is defined as the zip code from $S \bar{R}_j$'s with the greatest discharge relevance factor.

(v) If there is only a single applicant, then the assignment procedure is complete. If there are additional applicants, then steps (iii), and (iv) must be repeated until all applicants have been assigned to an existing subarea.

(2) The Commission shall amend Appendix A to reflect: (a) approved new licensed site(s) assigned to a specific hospital subarea; (b) hospital closures; and (c) licensure action(s) as appropriate.

(3) As directed by the Commission, new sub-area assignments established according to subsection (1)(a)(i) shall supersede Appendix A and shall be included as an amended appendix to these standards effective on the date determined by the Commission.

Section 4. Determination of the needed hospital bed supply

Sec. 4. (1) The determination of the needed hospital bed supply for a hospital subarea for a planning year shall be made using the MIDB and population estimates and projections by zip code in the following methodology:

(a) All hospital discharges for normal newborns (DRG 391) and psychiatric patients (ICD-9-CM codes 290 through 319 as a principal diagnosis) will be excluded.

(b) For each hospital subarea, calculate the number of patient days (take the patient days for each discharge and accumulate it within the respective age group) for the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 through 375 – obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older. Data from non-Michigan residents are to be included for each specific age group. Data from non-Michigan residents are to be included for each specific age group.

(c) For each hospital subarea, calculate the relevance index (%Z) for each zip code and for each of the following age groups: ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 THROUGH 375 – obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older.

(d) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective base year zip code and age group specific year population. The result will be the zip code allocations by age group for each subarea.

(e) For each hospital subarea, calculate the subarea base year population by age group by adding together all zip code population allocations calculated in (d) for each specific age group in that subarea. The result will be six population age groups for each subarea.

(f) For each hospital subarea, calculate the patient day use rates for ages 0 (excluding normal newborns) through 14 (pediatric), ages 15 through 44, female ages 15 through 44 (DRGs 370 THROUGH 375 – obstetrical discharges), ages 45 through 64, ages 65 through 74, and ages 75 and older by dividing the results of (b) by the results of (e).

(g) For each hospital subarea, multiply each zip code %Z calculated in (c) by its respective planning year zip code and age group specific year population. The results will be the projected zip code allocations by age group for each subarea.

(h) For each hospital subarea, calculate the subarea projected year population by age group by adding together all projected zip code population allocations calculated in (g) for each specific age group. The result will be six population age groups for each subarea.

(i) For each hospital subarea, calculate the subarea projected patient days for each age group by multiplying the six projected populations by age group calculated in step (h) by the age specific use rates identified in step (f).

(j) For each hospital subarea, calculate the adult medical/surgical subarea projected patient days by adding together the following age group specific projected patient days calculated in (i): ages 15 through 44, ages 45 through 64, ages 65 through 74, and ages 75 and older. The 0 (excluding normal newborns) through 14 (pediatric) and female ages 15 through 44 (DRGs 370 through 375 – obstetrical discharges) age groups remain unchanged as calculated in (i).

(k) For each hospital subarea, calculate the subarea projected average daily census (ADC) for three age groups: Ages 0 (excluding normal newborns) through 14 (pediatric), female ages 15 through 44 (DRGs 370 through 375 – obstetrical discharges), and adult medical surgical by dividing the results calculated in (j) by 365 (or 366 if the planning year is a leap year). Round each ADC to a whole number. This will give three ADC computations per subarea.

(l) For each hospital subarea and age group, select the appropriate subarea occupancy rate from the occupancy rate table in Appendix D.

(m) For each hospital subarea and age group, calculate the subarea projected bed need number of hospital beds for the subarea by age group by dividing the ADC calculated in (k) by the appropriate occupancy rate determined in (l). To obtain the total hospital bed need, add the three age group bed projections together. Round any part of a bed up to a whole bed.

Section 5. Bed Need

Sec. 5. (1) The bed-need numbers incorporated as part of these standards as Appendix C shall apply to projects subject to review under these standards, except where a specific CON review standard states otherwise.

(2) The Commission shall direct the Department, effective November 2004 and every two years thereafter, to re-calculate the acute care bed need methodology in Section 4, within a specified time frame.

(3) The Commission shall designate the base year and the future planning year which shall be utilized in applying the methodology pursuant to subsection (2).

(4) When the Department is directed by the Commission to apply the methodology pursuant to subsection (2), the effective date of the bed-need numbers shall be established by the Commission.


(5) As directed by the Commission, new bed-need numbers established by subsections (2) and (3) shall supersede the bed-need numbers shown in Appendix C and shall be included as an amended appendix to these standards.

Section 6. Requirements for approval -- new beds in a hospital

Sec. 6. (1) An applicant proposing new beds in a hospital, except an applicant meeting the requirements of subsection 2, 3, 4, OR 5 shall demonstrate that it meets all of the following:

(a) The new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

(b) The total number of existing hospital beds in the subarea to which the new beds will be assigned does not currently exceed the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subarea to which the beds will be assigned in accord with Section 3 of these standards.

(c) Approval of the proposed new beds in a hospital shall not result in the total number of existing hospital beds, in the subarea to which the new beds will be assigned, exceeding the needed hospital bed supply as set forth in Appendix C. The Department shall determine the subarea to which the beds will be assigned in accord with Section 3 of these standards. 

(2) An applicant proposing to begin operation as a new long-term (acute) care hospital or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all of the requirements of this subsection:

(a) If the long-term (acute) care hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as a long-term (acute) care hospital within 12 months after beginning operation, then it may apply for a six-month extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII requirements for PPS exemption as a long-term (acute) care hospital within the 12 or 18-month period, then the CON granted pursuant to this section shall expire automatically.

(b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following:

(i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital.

(ii) That the proposed new beds shall be for use in space currently licensed as part of the host hospital.

(iii) That upon non-renewal and/or termination of the lease, upon termination of the license issued under Part 215 of the act to the applicant for the new hospital, or upon noncompliance with the project delivery requirements or any other applicable requirements of these standards, the beds licensed as part of the new hospital must be disposed of by one of the following means:

(A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the long-term (acute) care hospital. In the event that the host hospital applies for a CON to acquire the long-term (acute) care hospital [including the beds leased by the host hospital to the long-term (acute) care hospital]

within six months following the termination of the lease with the long-term (acute) care hospital, it shall not be required to be in compliance with the hospital bed supply set forth in Appendix C if the host hospital proposes to add the beds of the long-term (acute) care hospital to the host hospital's medical/surgical licensed capacity and the application meets all other applicable project delivery requirements. The beds must be used for general medical/surgical purposes. Such an application shall not be subject to comparative review and shall be processed under the procedures for non-substantive review (as this will not be considered an increase in the number of beds originally licensed to the applicant at the host hospital);

(B) Delicensure of the hospital beds; or

(C) Acquisition by another entity that obtains a CON to acquire the new hospital in its entirety and that entity must meet and shall stipulate to the requirements specified in Section 6(2).

(c) The applicant or the current licensee of the new hospital shall not apply, initially or subsequently, for CON approval to initiate any other CON covered clinical services; provided, however, that this section is not intended, and shall not be construed in a manner which would prevent the licensee from contracting and/or billing for medically necessary covered clinical services required by its patients under arrangements with its host hospital or any other CON approved provider of covered clinical services.

(d) The new licensed hospital shall remain within the host hospital.

(e) The new hospital shall be assigned to the same subarea as the host hospital.

(f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute a change in bed capacity under Section 1(3) of these standards.

(g) The lease will not result in an increase in the number of licensed hospital beds in the subarea.

(h) Applications proposing a new hospital under this subsection shall not be subject to comparative review.

(3) An applicant proposing to add new hospital beds, as the receiving licensed hospital under Section 8, shall demonstrate that it meets all of the requirements of this subsection and shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(a) The approval of the proposed new hospital beds shall not result in an increase in the number of licensed hospital beds in the subarea.

(b) The proposed project to add new hospital beds, under this subsection, shall constitute a change in bed capacity under Section 1(3) of these standards.

(c) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(4) An applicant may apply for the addition of new beds if all of the following subsections are met. Further, an applicant proposing new beds at an existing licensed hospital site shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

(a) The beds are being added at the existing licensed hospital site.

(b) The hospital at the existing licensed hospital site has operated as follows for the previous, consecutive 12 months based on its existing licensed hospital bed capacity as documented on the most recent reports of the "Annual Hospital Statistical Questionnaire" or more current verifiable data:



Number of Licensed Hospital Beds	Average Occupancy
Fewer than 300	80% and above
300 or more	85% and above

(c) The number of beds that may be approved pursuant to this subsection shall be the number of beds necessary to reduce the occupancy rate for the hospital to 80 percent for hospitals with licensed beds of 300 or more and to 75 percent for hospitals with licensed beds of fewer than 300. The number of beds shall be calculated as follows:

(i) Divide the actual number of patient days of care provided during the most recent, consecutive 12-month period for which verifiable data are available to the department by .80 for hospitals with licensed beds of 300 or more and by .75 for hospitals with licensed beds of fewer than 300 to determine licensed bed days at 80 percent occupancy or 75 percent occupancy as applicable;

(ii) Divide the result of step (i) by 365 (or 366 for leap years) and round the result up to the next whole number;

(iii) Subtract the number of licensed beds as documented on the "Department Inventory of Beds" from the result of step (ii) and round the result up to the next whole number to determine the maximum number of beds that may be approved pursuant to this subsection.

(D) Applicants proposing to add new hospital beds under this subsection shall not be subject to comparative review.

(5) AN APPLICANT PROPOSING A NEW HOSPITAL IN A LIMITED ACCESS AREA SHALL NOT BE REQUIRED TO BE IN COMPLIANCE WITH THE NEEDED HOSPITAL BED SUPPLY SET FORTH IN APPENDIX C IF THE APPLICATION MEETS ALL OTHER APPLICABLE CON REVIEW STANDARDS, AGREES AND ASSURES TO COMPLY WITH ALL APPLICABLE PROJECT DELIVERY REQUIREMENTS, AND ALL OF THE FOLLOWING SUBSECTIONS ARE MET.

(A) THE PROPOSED NEW HOSPITAL SHALL HAVE 24/7 EMERGENCY SERVICES, OBSTETRICAL SERVICES, SURGICAL SERVICES, AND LICENSED ACUTE CARE BEDS AS DETERMINED BY THE BED NEED METHODOLOGY IN SECTION 4 AND AS SHOWN IN APPENDIX E.

(B) THE DEPARTMENT SHALL ASSIGN THE PROPOSED NEW HOSPITAL TO AN EXISTING SUBAREA.

(C) APPROVAL OF THE PROPOSED NEW BEDS IN A HOSPITAL IN A LIMITED ACCESS AREA SHALL NOT EXCEED THE BED NEED FOR THE LIMITED ACCESS AREA AS SET FORTH IN APPENDIX E.

Section 7. Requirements for approval -- replacement beds in a hospital in a replacement zone

Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing replacement beds in a hospital in the replacement zone shall demonstrate that the new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.

(2) In order to be approved, the applicant shall propose to (i) replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are located, and (ii) that the proposed new licensed site is in the replacement zone.

(3) An applicant proposing replacement beds in the replacement zone shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.

Section 8. Requirements for approval of an applicant proposing to relocate existing licensed hospital beds

Sec 8. (1) The proposed project to relocate beds, under this section, shall constitute a change in bed capacity under Section 1(4) of these standards.

(2) Any existing licensed acute care hospital may relocate all or a portion of its beds to another existing licensed acute care hospital located within the same subarea according to the provisions in this section.

(3) The hospital from which the beds are being relocated, and the hospital receiving the beds, shall not require any ownership relationship.

(4) The relocated beds shall continue to be counted in the inventory for the subarea but licensed to the recipient hospital.

(5) The relocation of beds from any other licensed acute care hospital within the subarea to any licensed acute care hospital within the subarea, shall not be subject to a mileage limitation.

Section 9. Project delivery requirements -- terms of approval for all applicants

Sec. 9. (1) An applicant shall agree that, if approved, the project shall be delivered in compliance with the following terms of CON approval:

- (a) Compliance with these standards
- (b) Compliance with applicable operating standards
- (c) Compliance with the following quality assurance standards:

(i) The applicant shall provide the Department with a notice stating the date the hospital beds are placed in operation and such notice shall be submitted to the Department consistent with applicable statute and promulgated rules.

(ii) The applicant shall assure compliance with Section 20201 of the Code, being Section 333.20201 of the Michigan Compiled Laws.

(iii) The applicant shall participate in a data collection network established and administered by the Department or its designee. The data may include, but is not limited to, annual budget and cost information and demographic, diagnostic, morbidity, and mortality information, as well as the volume of care provided to patients from all payor sources. The applicant shall provide the required data on a separate basis for each licensed site; in a format established by the Department, and in a mutually agreed upon media. The Department may elect to verify the data through on-site review of appropriate records.

(A) The applicant shall participate and submit data to the Michigan Inpatient Data Base (MIDB). The data shall be submitted to the Department or its designee.

(iv) An applicant shall participate in Medicaid at least 12 consecutive months within the first two years of operation and continue to participate annually thereafter.

(d) The applicant, to assure appropriate utilization by all segments of the Michigan population, shall:

- (i) Not deny services to any individual based on ability to pay or source of payment.
- (ii) Maintain information by source of payment to indicate the volume of care from each payor and non-payor source provided annually.
- (iii) Provide services to any individual based on clinical indications of need for the services.

(2) The agreements and assurances required by this section shall be in the form of a certification authorized by the governing body of the applicant or its authorized agent.

Section 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties

Sec. 10. Rural, micropolitan statistical area, and metropolitan statistical area Michigan counties, for purposes of these standards, are incorporated as part of these standards as Appendix B. The Department may amend Appendix B as appropriate to reflect changes by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget.

Section 11. Department inventory of beds

Sec. 11. The Department shall maintain and provide on request a listing of the Department inventory of beds for each subarea. HOSPITALS THAT HAVE STATE/FEDERAL CRITICAL ACCESS HOSPITAL DESIGNATION ARE EXCLUDED FROM THE BED INVENTORY.

Section 12. Effect on prior planning policies; comparative reviews

Sec. 12. (1) These CON review standards supersede and replace the CON standards for hospital beds approved by the CON Commission on MARCH 9, 2004 and effective JUNE 4, 2004.

(2) Projects reviewed under these standards shall be subject to comparative review except those projects meeting the requirements of Section 7 involving the replacement of beds in a hospital within the replacement zone and projects involving acquisition (including purchase, lease, donation or comparable arrangements) of a hospital.



Section 13. Additional requirements for applications included in comparative reviews

Sec. 13. (1) Any application subject to comparative review under Section 22229 of the Code being Section 333.22229 of the Michigan Compiled Laws or these standards shall be grouped and reviewed with other applications in accordance with the CON rules applicable to comparative reviews.



(2) Each application in a comparative review group shall be individually reviewed to determine whether the application has satisfied all the requirements of Section 22225 of the Code being Section 333.22225 of the Michigan Compiled Laws and all other applicable requirements for approval in the Code and these standards. If the Department determines that one or more of the competing applications satisfies all of the requirements for approval, these projects shall be considered qualifying projects. The Department shall approve those qualifying projects which, taken together, do not exceed the need, as defined in Section 22225(1), in the order the Department determines the projects most fully promote the availability of quality health services at reasonable cost.

Section 14. Documentation of market survey

Sec. 14. An applicant required to conduct a market survey under Section 3 shall specify how the market survey was developed. This specification shall include a description of the data source(s) used, assessments of the accuracy of these data, and the statistical method(s) used. Based on this documentation, the Department shall determine if the market survey is reasonable.

Section 15. Requirements for approval -- acquisition of a hospital

Sec. 15. (1) An applicant proposing to acquire a hospital shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C for the subarea in which the hospital subject to the proposed acquisition is assigned if the applicant demonstrates that all of the following are met:

- (a) the acquisition will not result in a change in bed capacity,
- (b) the licensed site does not change as a result of the acquisition,
- (c) the project is limited solely to the acquisition of a hospital with a valid license, and
- (d) if the application is to acquire a hospital, which was proposed in a prior application to be established as a long-term (acute) care hospital (LTAC) and which received CON approval, the applicant also must meet the requirements of Section 6(2). Those hospitals that received such prior approval are so identified in Appendix A.

XIII. Section 16. Requirements for approval – all applicants

Sec. 16. An applicant shall provide verification of Medicaid participation at the time the application is submitted to the Department. If the required documentation is not submitted with the application on the designated application date, the application will be deemed filed on the first applicable designated application date after all required documentation is received by the Department.

Section 17. Health service areas

Sec. 17. Counties assigned to each of the health service areas are as follows:

HSA	COUNTIES		
1 - Southeast	Livingston Macomb Wayne	Monroe Oakland	St. Clair Washtenaw
2 - Mid-Southern	Clinton Eaton	Hillsdale Ingham	Jackson Lenawee
3 - Southwest	Barry Berrien Branch	Calhoun Cass Kalamazoo	St. Joseph Van Buren
4 - West	Allegan Ionia Kent Lake	Mason Mecosta Montcalm Muskegon	Newaygo Oceana Osceola Ottawa
5 - GLS	Genesee	Lapeer	Shiawassee
6 - East	Arenac Bay Clare Gladwin Gratiot	Huron Iosco Isabella Midland Ogemaw	Roscommon Saginaw Sanilac Tuscola
7 - Northern Lower	Alcona Alpena Antrim Benzie Charlevoix Cheboygan	Crawford Emmet Gd Traverse Kalkaska Leelanau Manistee	Missaukee Montmorency Oscoda Otsego Presque Isle Wexford
8 - Upper Peninsula	Alger Baraga Chippewa Delta Dickinson	Gogebic Houghton Iron Keweenaw Luce	Mackinac Marquette Menominee Ontonagon Schoolcraft

**CON REVIEW STANDARDS
FOR HOSPITAL BEDS**

HOSPITAL SUBAREA ASSIGNMENTS

Health Service Area	Sub Area	Hospital Name	City
1 - Southeast			
	1A	North Oakland Med Centers (Fac #63-0110)	Pontiac
	1A	Pontiac Osteopathic Hospital (Fac #63-0120)	Pontiac
	1A	St. Joseph Mercy – Oakland (Fac #63-0140)	Pontiac
	1A	Select Specialty Hospital - Pontiac (LTAC - FAC #63-0172) *	Pontiac
	1A	Crittenton Hospital (Fac #63-0070)	Rochester
	1A	Huron Valley – Sinai Hospital (Fac #63-0014)	Commerce Township
	1A	Wm Beaumont Hospital (Fac #63-0030)	Royal Oak
	1A	Wm Beaumont Hospital – Troy (Fac #63-0160)	Troy
	1A	Providence Hospital (Fac #63-0130)	Southfield
	1A	Great Lakes Rehabilitation Hospital (Fac #63-0013)	Southfield
	1A	Straith Hospital for Special Surg (Fac #63-0150)	Southfield
	1A	The Orthopaedic Specialty Hospital (Fac #63-0060)	Madison Heights
	1A	St. John Oakland Hospital (Fac #63-0080)	Madison Heights
	1A	Southeast Michigan Surgical Hospital (Fac #50-0100)	Warren
	1B	Bi-County Community Hospital (Fac #50-0020)	Warren
	1B	St. John Macomb Hospital (Fac #50-0070)	Warren
	1C	Oakwood Hosp And Medical Center (Fac #82-0120)	Dearborn
	1C	Garden City Hospital (Fac #82-0070)	Garden City
	1C	Henry Ford –Wyandotte Hospital (Fac #82-0230)	Wyandotte
	1C	Select Specialty Hosp Wyandotte (LTAC - Fac #82-0272)*	Wyandotte
	1C	Oakwood Annapolis Hospital (Fac #82-0010)	Wayne
	1C	Oakwood Heritage Hospital (Fac #82-0250)	Taylor
	1C	Riverside Osteopathic Hospital (Fac #82-0160)	Trenton
	1C	Oakwood Southshore Medical Center (Fac #82-0170)	Trenton
	1C	Kindred Hospital – Detroit (Fac #82-0130)	Lincoln Park
	1D	Sinai-Grace Hospital (Fac #83-0450)	Detroit
	1D	Rehabilitation Institute of Michigan (Fac #83-0410)	Detroit
	1D	Harper University Hospital (Fac #83-0220)	Detroit
	1D	St. John Detroit Riverview Hospital (Fac #83-0034)	Detroit
	1D	Henry Ford Hospital (Fac #83-0190)	Detroit
	1D	St. John Hospital & Medical Center (Fac #83-0420)	Detroit
	1D	Children's Hospital of Michigan (Fac #83-0080)	Detroit
	1D	Detroit Receiving Hospital & Univ Hlth (Fac #83-0500)	Detroit
	1D	St. John Northeast Community Hosp (Fac #83-0230)	Detroit
	1D	Kindred Hospital–Metro Detroit (Fac #83-0520)	Detroit
	1D	SCCI Hospital-Detroit (LTAC - Fac #83-0521) *	Detroit
	1D	Greater Detroit Hosp–Medical Center (Fac #83-0350)	Detroit
	1D	Renaissance Hosp & Medical Centers (Fac #83-0390)	Detroit

1D United Community Hospital (Fac #83-0490)

Detroit

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

APPENDIX A (continued)

Health Service Area	Sub Area	Hospital Name	City
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1 – Southeast (continued)

1D	Harper-Hutzel Hospital (Fac #83-0240)	Detroit
1D	Select Specialty Hosp–NW Detroit (LTAC - Fac #83-0523)*	Detroit
1D	Bon Secours Hospital (Fac #82-0030)	Grosse Pointe
1D	Cottage Hospital (Fac #82-0040)	Grosse Pointe Farm
1E	Botsford General Hospital (Fac #63-0050)	Farmington Hills
1E	St. Mary Mercy Hospital (Fac #82-0190)	Livonia
1F	Mount Clemens General Hospital (Fac #50-0060)	Mt. Clemens
1F	Select Specialty Hosp – Macomb Co. (FAC #50-0111)*	Mt. Clemens
1F	St. John North Shores Hospital (Fac #50-0030)	Harrison Twp.
1F	St. Joseph's Mercy Hosp & Hlth Serv (Fac #50-0110)	Clinton Township
1F	St. Joseph's Mercy Hospital & Health (Fac #50-0080)	Mt. Clemens
1G	Mercy Hospital (Fac #74-0010)	Port Huron
1G	Port Huron Hospital (Fac #74-0020)	Port Huron
1H	St. Joseph Mercy Hospital (Fac #81-0030)	Ann Arbor
1H	University Of Michigan Health System (Fac #81-0060)	Ann Arbor
1H	Select Specialty Hosp–Ann Arbor (Ltac - Fac #81-0081)*	Ann Arbor
1H	Chelsea Community Hospital (Fac #81-0080)	Chelsea
1H	Saint Joseph Mercy Livingston Hosp (Fac #47-0020)	Howell
1H	Saint Joseph Mercy Saline Hospital (Fac #81-0040)	Saline
1H	Forest Health Medical Center (Fac #81-0010)	Ypsilanti
1H	Brighton Hospital (Fac #47-0010)	Brighton
1I	St. John River District Hospital (Fac #74-0030)	East China
1J	Mercy Memorial Hospital (Fac #58-0030)	Monroe

2 - Mid-Southern

2A	Clinton Memorial Hospital (Fac #19-0010)	St. Johns
2A	Eaton Rapids Medical Center (Fac #23-0010)	Eaton Rapids
2A	Hayes Green Beach Memorial Hosp (Fac #23-0020)	Charlotte
2A	Ingham Reg Med Cntr (Greenlawn) (Fac #33-0020)	Lansing
2A	Ingham Reg Med Cntr (Pennsylvania) (Fac #33-0010)	Lansing
2A	Edward W. Sparrow Hospital (Fac #33-0060)	Lansing
2A	Sparrow – St. Lawrence Campus (Fac #33-0050)	Lansing
2B	Carelink of Jackson (Ltac Fac #38-0030)*	Jackson
2B	W. A. Foote Memorial Hospital (Fac #38-0010)	Jackson
2C	Hillsdale Community Health Center (Fac #30-0010)	Hillsdale

2D Emma L. Bixby Medical Center (Fac #46-0020)
 2D Herrick Memorial Hospital (Fac #46-0030)

Adrian
 Tecumseh

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

APPENDIX A (continued)

Health Service Area	Sub Area	Hospital Name	City
3 – Southwest			
	3A	Borgess Medical Center (Fac #39-0010)	Kalamazoo
	3A	Bronson Methodist Hospital (Fac #39-0020)	Kalamazoo
	3A	Borgess-Pipp Health Center (Fac #03-0031)	Plainwell
	3A	Lakeview Community Hospital (Fac #80-0030)	Paw Paw
	3A	Bronson – Vicksburg Hospital (Fac #39-0030)	Vicksburg
	3A	Pennock Hospital (Fac #08-0010)	Hastings
	3A	Three Rivers Area Hospital (Fac #75-0020)	Three Rivers
	3A	Sturgis Hospital (Fac #75-0010)	Sturgis
	3A	Sempercare Hospital at Bronson (LTAC - Fac #39-0032)*	Kalamazoo
	3B	Fieldstone Ctr of Battle Crk. Health (Fac #13-0030)	Battle Creek
	3B	Battle Creek Health System (Fac #13-0031)	Battle Creek
	3B	Select Spec Hosp–Battle Creek (LTac - Fac #13-0111)*	Battle Creek
	3B	SW Michigan Rehab. Hosp. (Fac #13-0100)	Battle Creek
	3B	Oaklawn Hospital (Fac #13-0080)	Marshall
	3C	Community Hospital (Fac #11-0040)	Watervliet
	3C	Lakeland Hospital, St. Joseph (Fac #11-0050)	St. Joseph
	3C	Lakeland Specialty Hospital (LTAC - Fac #11-0080)*	Berrien Center
	3C	South Haven Community Hospital (Fac #80-0020)	South Haven
	3D	Lakeland Hospital, Niles (Fac #11-0070)	Niles
	3D	Lee Memorial Hospital (A) (Fac #14-0010)	Dowagiac
	3E	Community Hlth Ctr Of Branch Co (Fac #12-0010)	Coldwater
4 – WEST			
	4A	Memorial Medical Center Of West MI (Fac #53-0010)	Ludington
	4B	Kelsey Memorial Hospital (Fac #59-0050)	Lakeview
	4B	Mecosta County General Hospital (Fac #54-0030)	Big Rapids
	4C	Spectrum Hlth-Reed City Campus (Fac #67-0020)	Reed City
	4D	Lakeshore Community Hospital (Fac #64-0020)	Shelby
	4E	Gerber Memorial Hospital (Fac #62-0010)	Fremont
	4F	Carson City Hospital (Fac #59-0010)	Carson City
	4F	Gratiot Community Hospital (Fac #29-0010)	Alma

4G	Hackley Hospital (Fac #61-0010)	Muskegon
4G	Mercy Gen Hlth Partners—(Sherman) (Fac #61-0020)	Muskegon
4G	Mercy Gen Hlth Partners—(Oak) (Fac #61-0030)	Muskegon
4G	Lifecare Hospitals of Western MI (LTAC - Fac #61-0052)*	Muskegon
4G	Select Spec Hosp—Western MI (LTAC - Fac #61-0051)*	Muskegon

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

APPENDIX A (continued)

Health Service Area	Sub Area	Hospital Name	City
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4 – West (continued)

4G	North Ottawa Community Hospital (Fac #70-0010)	Grand Haven
4H	Spectrum Hlth—Blodgett Campus (Fac #41-0010)	E. Grand Rapids
4H	Spectrum Hlth—Butterworth Campus (Fac #41-0040)	Grand Rapids
4H	Spectrum Hlth—Kent Comm Campus (Fac #41-0090)	Grand Rapids
4H	Mary Free Bed Hospital & Rehab Ctr (Fac #41-0070)	Grand Rapids
4H	Metropolitan Hospital (Fac #41-0060)	Grand Rapids
4H	Saint Mary's Mercy Medical Center (Fac #41-0080)	Grand Rapids
4I	Sheridan Community Hospital (A) (Fac #59-0030)	Sheridan
4I	United Memorial Hospital & LTCU (Fac #59-0060)	Greenville
4J	Holland Community Hospital (Fac #70-0020)	Holland
4J	Zeeland Community Hospital (Fac #70-0030)	Zeeland
4K	Ionia County Memorial Hospital (Fac #34-0020)	Ionia
4L	Allegan General Hospital (Fac #03-0010)	Allegan

5 – GLS

5A	Memorial Healthcare (Fac #78-0010)	Owosso
5B	Genesys Reg Med Ctr—Hlth Park (Fac #25-0072)	Grand Blanc
5B	Hurley Medical Center (Fac #25-0040)	Flint
5B	Mclaren Regional Medical Center (Fac #25-0050)	Flint
5B	Select Specialty Hospital-Flint (LTAC - Fac #25-0071)*	Flint
5C	Lapeer Regional Hospital (Fac #44-0010)	Lapeer

6 – East

6A	West Branch Regional Medical Cntr (Fac #65-0010)	West Branch
6A	Tawas St Joseph Hospital (Fac #35-0010)	Tawas City
6B	Central Michigan Community Hosp (Fac #37-0010)	Mt. Pleasant
6C	Mid-Michigan Medical Center-Clare (Fac #18-0010)	Clare
6D	Mid-Michigan Medical Cntr - Gladwin (Fac #26-0010)	Gladwin

6D Mid-Michigan Medical Cntr - Midland (Fac #56-0020)

Midland

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) Hospitals THAT have state/federal critical access hospital designation (SEE SECTION 11).

APPENDIX A (continued)

Health Service Area	Sub Area	Hospital Name	City
=====			
6 – East (continued)			
6E		Bay Regional Medical Center (Fac #09-0050)	Bay City
6E		Bay Regional Medical Ctr-West (Fac #09-0020)	Bay City
6E		Samaritan Health Center (Fac #09-0051)	Bay City
6E		Bay Special Care (LTAC - Fac #09-0010)*	Bay City
6E		Standish Community Hospital (A) (Fac #06-0020)	Standish
6F		Select Specialty Hosp–Saginaw (LTAC - Fac #73-0062)*	Saginaw
6F		Covenant Medical Centers, Inc (Fac #73-0061)	Saginaw
6F		Covenant Medical Cntr–N Michigan (Fac #73-0030)	Saginaw
6F		Covenant Medical Cntr–N Harrison (Fac #73-0020)	Saginaw
6F		Healthsource Saginaw (Fac #73-0060)	Saginaw
6F		St. Mary's Medical Center (Fac #73-0050)	Saginaw
6F		Caro Community Hospital (Fac #79-0010)	Caro
6F		Hills And Dales General Hospital (Fac #79-0030)	Cass City
6G		Harbor Beach Community Hosp (A) (Fac #32-0040)	Harbor Beach
6G		Huron Medical Center (Fac #32-0020)	Bad Axe
6G		Scheurer Hospital (A) (Fac #32-0030)	Pigeon
6H		Deckerville Community Hospital (A) (Fac #76-0010)	Deckerville
6H		Mckenzie Memorial Hospital (A) (Fac #76-0030)	Sandusky
6I		Marlette Community Hospital (Fac #76-0040)	Marlette
7 - Northern Lower			
7A		Cheboygan Memorial Hospital (Fac #16-0020)	Cheboygan
7B		Charlevoix Area Hospital (Fac #15-0020)	Charlevoix
7B		Mackinac Straits Hospital (A) (Fac #49-0030)	St. Ignace
7B		Northern Michigan Hospital (Fac #24-0030)	Petoskey
7C		Rogers City Rehabilitation Hospital (Fac #71-0030)	Rogers City
7D		Otsego Memorial Hospital (Fac #69-0020)	Gaylord
7E		Alpena General Hospital (Fac #04-0010)	Alpena
7F		Kalkaska Memorial Health Center (A) (Fac #40-0020)	Kalkaska

7F Leelanau Memorial Health Center (A) (Fac #45-0020)
7F Munson Medical Center (Fac #28-0010)
7F Paul Oliver Memorial Hospital (A) (Fac #10-0020)

Northport
Traverse City
Frankfort

*This is a hospital that must meet the requirement(s) of Section 15(1)(d) - LTAC.

(A) Hospitals THAT have state/federal critical access hospital designation (SEE SECTION 11).



Health Service Area	Sub Area	Hospital Name	City
=====			
7 - Northern Lower (continued)			
	7G	Mercy Hospital - Cadillac (Fac #84-0010)	Cadillac
	7H	Mercy Hospital - Grayling (Fac #20-0020)	Grayling
	7I	West Shore Medical Center (Fac #51-0020)	Manistee
8 - UPPER PENINSULA			
	8A	Grand View Hospital (Fac #27-0020)	Ironwood
	8B	Ontonagon Memorial Hospital (A) (Fac #66-0020)	Ontonagon
	8C	Iron County General Hospital (Fac #36-0020)	Iron River
	8D	Baraga County Memorial Hospital (A) (Fac #07-0020)	L'anse
	8E	Keweenaw Memorial Medical Center (Fac #31-0010)	Laurium
	8E	Portage Health System (Fac #31-0020)	Hancock
	8F	Dickinson County Memorial Hospital (Fac #22-0020)	Iron Mountain
	8G	Bell Memorial Hospital (Fac #52-0010)	Ishpeming
	8G	Marquette General Hospital (Fac #52-0050)	Marquette
	8H	St. Francis Hospital (Fac #21-0010)	Escanaba
	8I	Munising Memorial Hospital (A) (Fac #02-0010)	Munising
	8J	Schoolcraft Memorial Hospital (A) (Fac #77-0010)	Manistique
	8K	Helen Newberry Joy Hospital (A) (Fac #48-0020)	Newberry
	8L	Chippewa Co. War Memorial Hosp (Fac #17-0020)	Sault Ste Marie

(A) Hospitals THAT have state/federal critical access hospital designation (SEE SECTION 11).



CON REVIEW STANDARDS
FOR HOSPITAL BEDS

Rural Michigan counties are as follows:

Alcona	Hillsdale	Ogemaw
Alger	Huron	Ontonagon
Antrim	Iosco	Osceola
Arenac	Iron	Oscoda
Baraga	Lake	Otsego
Charlevoix	Luce	Presque Isle
Cheboygan	Mackinac	Roscommon
Clare	Manistee	Sanilac
Crawford	Mason	Schoolcraft
Emmet	Montcalm	Tuscola
Gladwin	Montmorency	
Gogebic	Oceana	

Micropolitan statistical area Michigan counties are as follows:

Allegan	Gratiot	Mecosta
Alpena	Houghton	Menominee
Benzie	Isabella	Midland
Branch	Kalkaska	Missaukee
Chippewa	Keweenaw	St. Joseph
Delta	Leelanau	Shiawassee
Dickinson	Lenawee	Wexford
Grand Traverse	Marquette	

Metropolitan statistical area Michigan counties are as follows:

Barry	Ionia	Newaygo
Bay	Jackson	Oakland
Berrien	Kalamazoo	Ottawa
Calhoun	Kent	Saginaw
Cass	Lapeer	St. Clair
Clinton	Livingston	Van Buren
Eaton	Macomb	Washtenaw
Genesee	Monroe	Wayne
Ingham	Muskegon	

Source:

65 F.R., p. 82238 (December 27, 2000)
Statistical Policy Office
Office of Information and Regulatory Affairs
United States Office of Management and Budget

**CON REVIEW STANDARDS
FOR HOSPITAL BEDS**

The hospital bed need for purposes of these standards until otherwise changed by the Commission are as follows:

Health Service Area	SA No.	Bed Need	Bed Inventory 12-01-03*
1 - SOUTHEAST			
	1A	2693	3408
	1B	415	551
	1C	1372	2143
	1D	3098	4828
	1E	451	578
	1F	636	770
	1G	275	282
	1H	1431	1773
	1I	50	68
	1J	149	217
2 - MID-SOUTHERN			
	2A	866	1143
	2B	293	390
	2C	48	65
	2D	98	180
3 - SOUTHWEST			
	3A	763	1080
	3B	282	341
	3C	261	431
	3D	85	89
	3E	59	102
4 - WEST			
	4A	57	81
	4B	63	126
	4C	17	42
	4D	11	24
	4E	38	61
	4F	136	191
	4G	391	568
	4H	1240	1738
	4I	47	65
	4J	153	250
	4K	21	77
	4L	24	54

*Applicants must contact the Department to obtain the current number of beds in the Department inventory of beds. Note the figures in the Bed Inventory Column do not reflect any data regarding applications for beds under appeal or pending a final Department decision.

APPENDIX C (Continued)

Health Service Area	SA No.	Bed Need	Bed Inventory 12-01-03*
5 - GLS			
	5A	79	115
	5B	1120	1241
	5C	119	183
6 - EAST			
	6A	99	148
	6B	55	118
	6C	47	64
	6D	216	272
	6E	299	443
	6F	765	1091
	6G	43	64
	6H	13	40
	6I	24	48
7 - NORTHERN LOWER			
	7A	43	46
	7B	203	273
	7C	0	36
	7D	27	53
	7E	99	124
	7F	349	354
	7G	62	97
	7H	53	90
	7I	40	75
8 - UPPER PENINSULA			
	8A	24	54
	8B	7	25
	8C	21	36
	8D	11	24
	8E	50	85
	8F	88	96
	8G	228	358
	8H	57	110
	8I	4	25
	8J	7	25
	8K	9	25
	8L	52	82

*Applicants must contact the Department to obtain the current number of beds in the Department inventory of beds. Note the figures in the Bed Inventory Column do not reflect any data regarding applications for beds under appeal or pending a final Department decision.

OCCUPANCY RATE TABLE

APPENDIX D



Adult Medical/Surgical					Pediatric Beds				
Beds					Beds				
ADC >=	ADC<	Occup	Start	Stop	ADC >	ADC<=	Occup	Start	Stop
	30	0.60		<=50		30	0.50		<=50
31	32	0.60	52	52	30	33	0.50	61	66
32	34	0.61	53	56	34	40	0.51	67	79
35	37	0.62	57	60	41	46	0.52	80	88
38	41	0.63	61	65	47	53	0.53	89	100
42	46	0.64	66	72	54	60	0.54	101	111
47	50	0.65	73	77	61	67	0.55	112	121
51	56	0.66	78	85	68	74	0.56	122	131
57	63	0.67	86	94	75	80	0.57	132	139
64	70	0.68	95	103	81	87	0.58	140	149
71	79	0.69	104	114	88	94	0.59	150	158
80	89	0.70	115	126	95	101	0.60	159	167
90	100	0.71	127	140	102	108	0.61	168	175
101	114	0.72	141	157	109	114	0.62	176	182
115	130	0.73	158	177	115	121	0.63	183	190
131	149	0.74	178	200	122	128	0.64	191	198
150	172	0.75	201	227	129	135	0.65	199	206
173	200	0.76	228	261	136	142	0.66	207	213
201	234	0.77	262	301	143	149	0.67	214	220
235	276	0.78	302	350	150	155	0.68	221	226
277	327	0.79	351	410	156	162	0.69	227	232
328	391	0.80	411	484	163	169	0.70	233	239
392	473	0.81	485	578	170	176	0.71	240	245
474	577	0.82	579	696	177	183	0.72	246	252
578	713	0.83	697	850	184	189	0.73	253	256
714	894	0.84	851	894	190	196	0.74	257	262
895		0.85	>=1054		197		0.75	>=263	

Obstetric Beds				
Beds				
ADC >	ADC<=	Occup	Start	Stop
	30	0.50		<=50
30	33	0.50	61	66
34	40	0.51	67	79
41	46	0.52	80	88
47	53	0.53	89	100
54	60	0.54	101	111
61	67	0.55	112	121
68	74	0.56	122	131
75	80	0.57	132	139
81	87	0.58	140	149
88	94	0.59	150	158
95	101	0.60	159	167
102	108	0.61	168	175
109	114	0.62	176	182

115	121	0.63	183	190
122	128	0.64	191	198
129	135	0.65	199	206
136	142	0.66	207	213
143	149	0.67	214	220
150	155	0.68	221	226
156	162	0.69	227	232
163	169	0.70	233	239
170	176	0.71	240	245
177	183	0.72	246	252
184	189	0.73	253	256
190	196	0.74	257	262
197		0.75	>=263	

LIMITED ACCESS AREAS

APPENDIX E



**MICHIGAN DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH AND MEDICAL AFFAIRS**

**CON REVIEW STANDARDS FOR HOSPITAL BEDS
-- ADDENDUM FOR PROJECTS FOR HIV INFECTED INDIVIDUALS --**

(By authority conferred on the CON Commission by sections 22215 and 22217 of Act No. 368 of the Public Acts of 1978, as amended, and sections 7 and 8 of Act No. 306 of the Public Acts of 1969, as amended, being sections 333.22215, 333.2217, 24.207, and 24.208 of the Michigan Compiled Laws.)

XIV. Section 1. Applicability; definitions

Sec. 1. (1) This addendum supplements the CON Review Standards for Hospital Beds and may be used for determining the need for projects established to meet the needs of HIV infected individuals.

(2) Except as provided by sections 2 and 3 below, these standards supplement and do not supercede the requirements and terms of approval required by the CON Review Standards for Hospital Beds.

(3) The definitions that apply to the CON Review Standards for Hospital Beds apply to these standards.

(4) "HIV infected" means that term as defined in Section 5101 of the Code.

(5) Planning area for projects for HIV infected individuals means the State of Michigan.

Section 2. Requirements for approval; change in bed capacity

Sec. 2. (1) A project which, if approved, will increase the number of licensed hospital beds in an overbedded subarea or will result in the total number of existing hospital beds in a subarea exceeding the needed hospital bed supply as determined under the CON Review Standards for Hospital Beds may, nevertheless, be approved pursuant to subsection (3) of this addendum.

(2) Hospital beds approved as a result of this addendum shall be included in the Department inventory of existing beds in the subarea in which the hospital beds will be located. Increases in hospital beds approved under this addendum shall cause subareas currently showing a current surplus of beds to have that surplus increased.

(3) In order to be approved under this addendum, an applicant shall demonstrate all of the following:
(a) The Director of the Department has determined that action is necessary and appropriate to meet the needs of HIV infected individuals for quality, accessible and efficient health care.

(b) The hospital will provide services only to HIV infected individuals.

(c) The applicant has obtained an obligation, enforceable by the Department, from existing licensed hospital(s) in any subarea of this state to voluntarily delicense a number of hospital beds equal to the number proposed in the application. The effective date of the delicensure action will be the date the beds approved pursuant to this addendum are licensed. The beds delicensed shall not be beds already subject to delicensure under a bed reduction plan.

(d) The application does not result in more than 20 beds approved under this addendum in the State.

(4) In making determinations under Section 22225(2)(a) of the Code, for projects under this addendum, the Department shall consider the total cost and quality outcomes for overall community health systems for services in a dedicated portion of an existing facility compared to a separate aids facility and has determined that there exists a special need, and the justification of any cost increases in terms of important quality/access improvements or the likelihood of future cost reductions, or both.

Section 3. Project delivery requirements--additional terms of approval for projects involving HIV infected individuals approved under this addendum.

Sec. 3. (1) An applicant shall agree that, if approved, the services provided by the beds for HIV infected individuals shall be delivered in compliance with the following terms of CON approval:

(a) The license to operate the hospital will be limited to serving the needs of patients with the clinical spectrum of HIV infection and any other limitations established by the Department to meet the purposes of this addendum.

(b) The hospital shall be subject to the general license requirements of Part 215 of the Code except as waived by the Department to meet the purposes of this addendum.

(c) The applicant agrees that the Department shall revoke the license of the hospital if the hospital provides services to inpatients other than HIV infected individuals.

Section 4. Comparative reviews

Sec. 4. (1) Projects proposed under Section 3 shall be subject to comparative review.



University of Michigan
Health System
Ann Arbor, MI 48109-0474

Statement on Behalf of University of Michigan Health System

Good Morning. My name is Mark Mailloux and I am Senior Health System Planner at the University of Michigan Health System.

The UMHS would like to thank the Standard Advisory Committee for all of the work it has done dealing with a complicated issue. The UHMS would also like to lend its support for the inclusion of a "high occupancy" provision in the bed standards.

The Commission has recognized the complications due to a hospital's high occupancy by approving language allowing applicants to expand their bed complement in the past.

UHMS supports the concept that the provision must be based on demonstrated occupancy, and further suggests it must provide any qualifying hospital with the added capacity to meet both its short and intermediate term needs. Any qualifying hospital should be required to provide the MDCH with a plan detailing how these beds would be put into service.

In addition, we believe that special consideration should be provided to children's hospitals or affiliated children's hospitals (as defined by N.A.C.H). In recognition of the special needs/demands of sick children, a 75% occupancy factor should be utilized here.

The Commission has put forth special consideration for pediatric patients in other standards. The MRI Standards address pediatric situations in two areas.

1) Establishment of dedicated pediatric MRI units are exempt from meeting the standards put forth for MRI initiation; and 2) For non-dedicated pediatric units each MRI visit involving a pediatric patient shall receive a .25 procedure adjustment (increase) to the base value of the visit.

The Cardiac Catheterization standards also apply a multiplier to all pediatric procedures. This multiplier is applied for calculating and evaluating utilization of cardiac catheterization laboratory or multi purpose special radiological room.

Generally, we would recommend language as follows:

"Any hospital which sustains an 85% occupancy rate on its licensed beds for twelve (12) consecutive months, shall be allowed to expand its licensed bed complement by 10%. The hospital shall provide the Department with a plan for the expanded bed use. A children's hospital, or an affiliated children's hospital (as defined by N.A.C.H) with a minimum of 150 (licensed) beds, shall maintain an occupancy of 75% for purposes of the occupancy standard."